FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043158

Facility Name: TIMBER POINT HEALTHCARE CENTER

Address: 205 EAST SPRING ST (Number) CAMP POINT (City) 62320 (Zip Code)

County: ADAMS

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4186824

Date of Initial License for Current Owners: 01/01/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHERWIN I. RAY

(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA/PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD
3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1

(Telephone) (847) 675-3585 Fax (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Previe

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,188	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,188	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,817	1,817	8
9	SNF/PED					9
10	ICF	18,648	6,098		24,746	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,648	6,098	1,817	26,563	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 61.51%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 1817

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number TIMBER POINT HEALTHCARE CEN # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	117,899	10,227	6,122	134,248		134,248	0	134,248			1
2	Food Purchase		105,057		105,057		105,057	(996)	104,061			2
3	Housekeeping	104,522	12,998	0	117,520		117,520	0	117,520			3
4	Laundry	21,315	9,523	0	30,838		30,838	0	30,838			4
5	Heat and Other Utilities			92,813	92,813		92,813	220	93,033			5
6	Maintenance	34,688	32,817	15,480	82,985		82,985	4,886	87,871			6
7	Other (specify):*			4,709	4,709		4,709	0	4,709			7
8	**TOTAL General Services**	278,424	170,622	119,124	568,170		568,170	4,110	572,280			8
	B. Health Care and Programs											
9	Medical Director			6,400	6,400		6,400	0	6,400			9
10	Nursing and Medical Records	642,647	40,415	50	683,112		683,112	12,672	695,784			10
10a	Therapy	44,720	2,246	31,987	78,953		78,953	(3,779)	75,174			10a
11	Activities	40,974	887	0	41,861		41,861	0	41,861			11
12	Social Services	0		2,384	2,384		2,384	0	2,384			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			0				0				14
15	Other (specify):*							0				15
16	**TOTAL Health Care and Progra**	728,341	43,548	40,821	812,710		812,710	8,893	821,603			16
	C. General Administration											
17	Administrative	60,117		77,000	137,117		137,117	(50,510)	86,607			17
18	Directors Fees			0				0				18
19	Professional Services			135,792	135,792		135,792	(95,052)	40,740			19
20	Dues, Fees, Subscriptions & Promotions			47,675	47,675		47,675	(16,560)	31,115			20
21	Clerical & General Office Expense	81,836	9,003	68,511	159,350		159,350	(13,312)	146,038			21
22	Employee Benefits & Payroll Taxes			145,423	145,423		145,423	0	145,423			22
23	Inservice Training & Education			0				514	514			23
24	Travel and Seminar			2,142	2,142		2,142	57	2,199			24
25	Other Admin. Staff Transportation			5,313	5,313		5,313	651	5,964			25
26	Insurance-Prop.Liab.Malpractice			67,505	67,505		67,505	1,930	69,435			26
27	Other (specify):*			0				13,433	13,433			27
28	**TOTAL General Administration**	141,953	9,003	549,361	700,317		700,317	(158,849)	541,468			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,148,718	223,173	709,306	2,081,197		2,081,197	(145,846)	1,935,351			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number TIMBER POINT HEALTHCARE CEN # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			4,731	4,731		4,731	53,600	58,331			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			96,664	96,664		96,664	112,776	209,440			32
33	Real Estate Taxes			78,955	78,955		78,955	0	78,955			33
34	Rent-Facility & Grounds			104,000	104,000		104,000	(101,080)	2,920			34
35	Rent-Equipment & Vehicles			30,495	30,495		30,495	(7,611)	22,884			35
36	Other (specify):*							0				36
37	TOTAL Ownership			314,845	314,845		314,845	57,685	372,530			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		44,532	78,346	122,878		122,878	(22,678)	100,200			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			64,782	64,782		64,782	0	64,782			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		44,532	143,128	187,660		187,660	(22,678)	164,982			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,148,718	267,705	1,167,279	2,583,702	0	2,583,702	(110,839)	2,472,863			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(3,476)	30		9
10	Interest and Other Investment Income	(191)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(996)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(311)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(16,752)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(433)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	(1,410)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (23,569)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(87,270)	SCHED	34
35	Other- Attach Schedule	0	TTACHED	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (87,270)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (110,839)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.

The amounts in columns F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name TIMBER POINT HEALTHCARE CENTER

IDP 0042158

Report Period Beginning: 01/01/2008

Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V Line	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(98)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	(1,420)
7	**Sale of Supplies to Non-Patients**	0	10	**Line 7**	0
8	**Laundry for Non-Patients**	0	4	**Line 8**	(2,400)
9	**Non-Straightline Depreciation**	(3,476)	30	**Line 9**	0
10	**Interest and Other Investment Income**	(191)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	2	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(996)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	25	**Line 15**	0
17	**Non-Care Related Fees**	0	20	**Line 16**	0
18	**Fines and Penalties**	(311)	21	**Line 17**	0
19	**Entertainment**	0	20	**Line 18**	0
20	**Contributions**	0	20	**Line 19**	0
21	**Owner or Key-Man Insurance**	0	22	**Line 20**	(17,135)
22	**Special Legal Fees & Legal Retainers**	0	19	**Line 21**	(717)
23	**Malpractice Insurance for Individuals**	0	26	**Line 22**	0
24	**Bad Debt**	0	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(16,752)	20	**Line 24**	0
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	13	**Line 26**	0
28	**Yellow Page Advertising**	(433)	20	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(17,499)
30	**Donated Goods**	0	0	**Line 29**	(19,907)
31	**Amortization Expense**	0	0	**Line 30**	(5,476)
32	Refloral Maintenance	(1,410)	6	**Line 31**	0
33				**Line 32**	(186)
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	(5,686)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(93,599)
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Print Other Adjustments

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(996)	0	0	0	0	0	0	0	0	0	0	(996)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	220	0	0	0	0	0	0	0	0	220	5
6	Maintenance	(1,410)	0	6,296	0	0	0	0	0	0	0	0	4,886	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,406)	0	6,516	0	0	0	0	0	0	0	0	4,110	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	12,672	0	0	0	0	0	0	0	0	12,672	10
10a	Therapy	0	(24,397)	20,618	0	0	0	0	0	0	0	0	(3,779)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	(24,397)	33,290	0	0	0	0	0	0	0	0	8,893	16
	C. General Administration													
17	Administrative	0	(77,000)	26,490	0	0	0	0	0	0	0	0	(50,510)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(96,800)	1,748	0	0	0	0	0	0	0	0	(95,052)	19
20	Fees, Subscriptions & Promotions	(17,185)	0	625	0	0	0	0	0	0	0	0	(16,560)	20
21	Clerical & General Office Expenses	(311)	(43,560)	30,559	0	0	0	0	0	0	0	0	(13,312)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	514	0	0	0	0	0	0	0	0	514	23
24	Travel and Seminar	0	0	57	0	0	0	0	0	0	0	0	57	24
25	Other Admin. Staff Transportation	0	0	651	0	0	0	0	0	0	0	0	651	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,930	0	0	0	0	0	0	0	0	1,930	26
27	Other (specify):*	0	0	13,433	0	0	0	0	0	0	0	0	13,433	27
28	**TOTAL General Administration**	(17,496)	(217,360)	76,007	0	0	0	0	0	0	0	0	(158,849)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,902)	(241,757)	115,813	0	0	0	0	0	0	0	0	(145,846)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(3,476)	52,295	4,781	0	0	0	0	0	0	0	0	53,600	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(191)	112,487	480	0	0	0	0	0	0	0	0	112,776	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(104,000)	2,920	0	0	0	0	0	0	0	0	(101,080)	34
35	Rent-Equipment & Vehicles	0	0	(7,611)	0	0	0	0	0	0	0	0	(7,611)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,667)	60,782	570	0	0	0	0	0	0	0	0	57,685	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(77,189)	54,511	0	0	0	0	0	0	0	0	(22,678)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Cent**	0	(77,189)	54,511	0	0	0	0	0	0	0	0	(22,678)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(23,569)	(258,164)	170,894	0	0	0	0	0	0	0	0	(110,839)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe TIMBER POINT HEALTHCARE CENTEI # 0043158 Report Period Beginning 01/01/2000 Ending 12/31/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
SEE ATTACHED SCHEDULE				TIMBER POINT ASSOCIATES LLC		
					NILES	REAL ESTATE
				CAREPLUS REHABILITATIVE SERVICES		
					NILES	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	Amount	4	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
V	17	MANAGEMENT FEES	77,000		CAREPLUS MGMT INC	6	6	(77,000)	1	-77000
V	19	ADMIN. CONSULTANT FEES	88,000		" "			(88,000)	2	-88000
V	19	DATA PROCESSING FEES	8,800		" "			(8,800)	3	-8800
V	21	CLERICAL FEES	42,560		" "			(42,560)	4	-43560
V									5	
V									6	
V	24	RENT	104,000		TIMBER POINT ASSOCIATES LLC			(104,000)	7	-104000
V	20	RL DEPRECIATION			" "		52,295	52,295	8	52295
V	22	INTEREST			" "		112,487	112,487	9	112487
V									10	
V									11	
V	10a	THERAPY SERVICES	24,397		CAREPLUS REHABILITATIVE SERVICE			(24,397)	12	-24397
V	39	ANCILLARY SERVICES	77,189		" "			(77,189)	13	-77189
Total			422,946				164,782	(258,164)	14	

* Total must agree with the amount recorded on line 34 of Schedule V

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
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4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	1	DIETARY SALARIES	$	CAREPLUS MGMT INC		$ 0	$	15	
16	V	5	ELECTRICITY		" "		220	220	16	220
17	V	6	REPAIRS		" "		386	386	17	386
18	V	6	MAINTENANCE SALARIES		" "		5,910	5,910	18	5910
19	V	10	NURSING		" "		12,672	12,672	19	12672
20	V	10a	THERAPY SALARIES		" "		3,389	3,389	20	3389
21	V	17	ADMIN SALARIES		" "		26,490	26,490	21	26490
22	V	19	PROFESSIONAL FEES		" "		1,748	1,748	22	1748
23	V	20	DUES/LICENSES/WANT ADS		" "		625	625	23	625
24	V	21	OFFICE SALARIES/EXPENSES		" "		30,559	30,559	24	30559
25	V	23	SEMINARS		" "		514	514	25	514
26	V	24	TRAVEL		" "		57	57	26	57
27	V	25	TRANSPORTATION		" "		651	651	27	651
28	V	26	INSURANCE		" "		1,930	1,930	28	1930
29	V	27	EMPLOYEE BENEFITS		" "		13,433	13,433	29	13433
30	V	30	SL DEPRECIATION		" "		4,781	4,781	30	4781
31	V	32	INTEREST		" "		480	480	31	480
32	V	34	OFFICE RENT		" "		2,920	2,920	32	2920
33	V	35	EQUIP RENT/AUTO LEASE	11,255	" "		3,644	(7,611)	33	-7611
34	V								34	
35	V								35	
36	V								36	
37	V	10a	THERAPY SERVICES		CAREPLUS REHABILITATIVE SERVICES		17,229	17,229	37	17229
38	V	39	ANCILLARY THERAPY		" "		54,511	54,511	38	54511
39	Total			$ 11,255			$ 182,149	$ * 170,894	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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Print Page 6

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STATE OF ILLINOIS

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Print Page 6

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Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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Facility Name & ID Number TIMBER POINT HEALTHCARE CEN # 0043158 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN I. RAY	PRESIDENT	ADMIN, FINAN	0.33	SEE ATTACHED	2.4	4.10	SALARY	7,576	17-7	2
3	JAKOB BAKST	DIR OPERATION	ADMIN, CONSU	0.33	SCHEDULES	2.4	4.10	SALARY	7,576	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 15,152		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Previe

the name(s)
PORTS.

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MGMT
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	559,284	11	$ 97,227	$ 97,227	26,563	$	1
2	5	ELECTRICITY	" "	648,651	14	5,352		26,563	220	2
3	6	REPAIRS	" "	648,651	14	9,448		26,563	386	3
4	6	MAINTENANCE SALARIES	" "	648,651	14	144,297	144,297	26,563	5,910	4
5	10	NURSING	" "	648,651	14	309,417	309,417	26,563	12,672	5
6	10a	THERAPY SALARIES	" "	578,314	12	73,756	73,756	26,563	3,389	6
7	17	ADMIN SALARIES	" "	648,651	14	646,825	646,825	26,563	26,490	7
8	19	PROFESSIONAL FEES	" "	648,651	14	42,748		26,563	1,748	8
9	20	DUES/LICENSES/WANT AD	" "	648,651	14	15,220		26,563	625	9
10	21	OFFICE SALARIES/EXPEN	" "	648,651	14	746,225	559,379	26,563	30,559	10
11	23	SEMINARS	" "	648,651	14	12,554		26,563	514	11
12	24	TRAVEL	" "	648,651	14	1,390		26,563	57	12
13	25	TRANSPORTATION	" "	648,651	14	15,846		26,563	651	13
14	26	INSURANCE	" "	648,651	14	47,123		26,563	1,930	14
15	27	EMPLOYEE BENEFITS	" "	648,651	14	328,053		26,563	13,433	15
16	30	SL DEPRECIATION	" "	648,651	14	116,734		26,563	4,781	16
17	32	INTEREST	" "	648,651	14	11,707		26,563	480	17
18	34	OFFICE RENT	" "	648,651	14	71,276		26,563	2,920	18
19	35	EQUIP RENT/AUTO LEASE	" "	648,651	14	88,968		26,563	3,644	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,784,166	$ 1,830,901		$ 110,409	25

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Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

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B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

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Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

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Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number TIMBER POINT HEALTHCARE CEN' # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: ROSE GARDEN CARE CENTER LLC						$	$			$	1
2	AMERICAN NATIONAL BANK	X		MORTGAGE	$12,698.00	09/98	1,600,000	1,400,291	08/2018	7.21	112,487	2
3												3
4												4
5	CAREPLUS MANAGEMENT ALLOCATION: GRAND NATIONAL BK LOC, ETC											5
	Working Capital											
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND					PRIME+	63,064	6
7	SHAREHOLDER / PARTN	X		WORKING CAPITAL							33,600	7
8												8
9	TOTAL Facility Related				$12,698.00		$ 1,600,000	$ 1,400,291			$ 209,151	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,600,000	$ 1,400,291			$ 209,151	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Numbe TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	79,520	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	78,845	2
3. Under or (over) accrual (line 2 minus line 1).	$	(675)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	79,630	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	78,955	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	67,349	8
	1996		9
	1997	80,032	10
	1998	78,736	11
	1999	78,845	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Numb TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	159,000	1998	$ 118,000	1
2					2
3	TOTALS	159,000		$ 118,000	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	RELATED PARTY: TIMBER POINT ASSOCIATES				$	$		$	$	$	4
5	118		1998		1,120,000	28,717	39	28,717		84,997	5
6											6
7											7
8	RELATED PARTY : CAREPLUS MANAGEMENT					43		43			8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	REMODEL KITCHEN			1998	5,569	143	39	143		411	9
10	BUILDING SIGN			1998	2,101	54	39	54		146	10
11	AIR CONDITIONING SYSTEM REPAIR			1998	3,625	93	39	93		244	11
12	FLOORING			1998	4,027	103	39	103		236	12
13	GENERATOR			1999	10,509	269	39	269		280	13
14	LINE DRAPERY			2000	12,176	1,740	20	304	(1,436)	304	14
15	ROOF TOP A/C UNIT			2000	2,585	35	27.5	35		35	15
16											16
17											17
18											18
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 31,197		$ 29,761	$ (1,436)	$ 86,653	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 8,733	$ 1,932	$ 9,506	$ 7,574	3-10 YR	$ 26,486	37
38	Current Year Purchases	2,535	362	127	(235)	10 YR	127	38
39	Fully Depreciated Assets							39
40	RELATED PARTY	118,000	25,376	16,538	(8,838)			40
41	TOTALS	$ 129,268	$ 27,670	$ 26,171	$ (1,499)		$ 26,613	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	RELATED PARTY - TIMBER POINT ASSOCIATES LLC			$	$	$	$		$	42
43	FACILITY VAN		1998	23,698	2,940	2,399	(541)			43
44										44
45										45
46	TOTALS			$ 23,698	$ 2,940	$ 2,399	$ (541)		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 61,807	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 58,331	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (3,476)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 113,266	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
   This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: [ ] YES [ ] NO Terms: _____ *

10. Effective dates of current rental agreement:
    Beginning _____
    Ending _____

11. Rent to be paid in future years under the curre rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipm $ 23,570 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY VAN	99 DODGE VAN	$	$ 6,925	17
18					18
19					19
20					20
21	TOTAL		$	$ 6,925	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ___

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units	Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs		$		$ 28,407	$		$ 28,407	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				794			794	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				48,354			48,354	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-2	# of prescrpts					38,145		38,145	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): SUPPLIES,LAB,RE	39-2					189	6,989		7,178	13
14	TOTAL				$		$ 77,744	$ 45,134		$ 122,878	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	678,821		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,613		6
7	Other Prepaid Expenses	137,579		7
8	Accounts Receivable (owners or related parties)	55,000		8
9	Other(specify): RE ESCROW	74,674		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 975,687	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	40,593		15
16	Equipment, at Historical Cost	11,268		16
17	Accumulated Depreciation (book methods)	(7,504)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 44,357	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,020,044	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 512,857	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,755		28
29	Short-Term Notes Payable	804,747		29
30	Accrued Salaries Payable	22,575		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,252		31
32	Accrued Real Estate Taxes(Sch.IX-B)	79,630		32
33	Accrued Interest Payable	6,814		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,437,630	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	200,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 200,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,637,630	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (617,586)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,020,044	$	48

***(See instructions.)**

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (401,229)	1
2	Restatements (describe):		2
3	POST CLOSING ADJUSTMENT	(12,085)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (413,314)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(204,272)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (204,272)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (617,586)	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,375,397	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,375,397	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	3,842	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,842	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	191	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 191	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 2,379,430	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 568,170	31
32	Health Care	812,710	32
33	General Administration	700,317	33
	B. Capital Expense		
34	Ownership	314,845	34
	C. Ancillary Expense		
35	Special Cost Centers	122,878	35
36	Provider Participation Fee	64,782	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,583,702	40
41	**Income before Income Taxes (line 30 minus line 40)****	(204,272)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ (204,272)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number TIMBER POINT HEALTHCARE CENTER # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,984	2,080	$ 38,318	$ 18.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,482	4,822	69,434	14.40	3
4	Licensed Practical Nurses	15,951	17,723	211,793	11.95	4
5	Nurse Aides & Orderlies	36,227	36,654	323,102	8.81	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,190	7,434	44,720	6.02	8
9	Activity Director	2,189	2,350	18,759	7.98	9
10	Activity Assistants	3,082	3,213	22,215	6.91	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,860	1,988	15,907	8.00	13
14	Head Cook	5,762	5,913	42,331	7.16	14
15	Cook Helpers/Assistants	8,325	8,598	59,661	6.94	15
16	Dishwashers					16
17	Maintenance Workers	5,039	5,323	34,688	6.52	17
18	Housekeepers	10,712	12,321	104,522	8.48	18
19	Laundry	3,583	3,749	21,315	5.69	19
20	Administrator	2,040	2,240	60,117	26.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,255	8,872	79,467	8.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify P COORDINAT	117	118	2,369	20.08	33
34	TOTAL (lines 1 - 33)	116,798	123,398	$ 1,148,718 *	$ 9.31	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 4,659	1-3	35
36	Medical Director		6,400	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		0	10-3	39
40	Physical Therapy Consultant		5,400	10a-3	40
41	Occupational Therapy Consultant		10,855	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		1,919	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		2,384	12-3	45
46	Other(specify)				46
47	PSYCHO-SOCIAL CONSULTANT		0	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 31,617		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number TIMBER POINT HEALTHCARE CENTE # 0043158 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PAM HERMON	ADMIN	0.00%	$ 60,117
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,117

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 77,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 77,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
CAREPLUS	DATA PROCESSING	8,800
AMERICAN DATA	DATA PROCESSING	535
HDSI	DATA PROCESSING	1,199
KBKB, Ltd.	ACCOUNTING	19,600
MEYER MEGENCE	LEGAL	11,872
GERALD T. TIMMERWILKE	LEGAL	238
PERSONNEL PLANNERS	UC CONSULTANT	1,698
CAREPLUS	ADMIN CONSULTANT	88,000
RICHARD PEELO	MEDICARE CONSULTAN	3,850
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 135,792

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,566
Unemployment Compensation Insurance	18,609
FICA Taxes	86,427
Employee Health Insurance	6,070
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	0
EMPLOYEE BENEFITS-OTHER	5,751
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	0
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 145,423

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	19,409
Health Care Worker Background Chec	219
(Indicate # of checks performed)	
ADV & PROMO/MARKETING	17,185
DUES & SUBSCRIPTIONS	10,424
LICENSES & PERMITS	438
TRUST FEES, CONTRIBUTIONS,etc.	0
MGMT CO ALLOCATION	625
LESS TRUST FEES, CONTRIB, etc.	0
Less: Public Relations Expense	( )
Non-allowable advertising	(16,752)
Yellow page advertising	(433)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,115

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	57
Seminar Expense	
EDUCATION & SEMINAR	2,142
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,199

**See instructions.

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